Communicable Disease UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health Vol. 11, No.1 Winter 2003

Vaccines are Good, Disease is Bad

As parental concerns about vaccine- preventable diseases and their complications have waned, questions and misconceptions about vaccine safety have increased. This was highlighted by a recent national survey by Gellin et al.[1], which found that although the majority of parents supported immunization, 25% believed that too many vaccinations could weaken the immune system and 23% believed that children get too many immunizations.

Vaccine Benefits Outweigh Risks

The question on the minds of many parents when faced with vaccinating their children is "Are vaccines safe?" If you define "safe" as being free from any possible negative effects, then the answer is no. Vaccines, as do all medicines, carry some degree of risk and possible side effects. Although most side effects are mild, such as local reactions, in rare instances some are more severe. The more important question should be, "Do the benefits of getting the vaccine (avoiding disease) outweigh the risks (side effects)?"

For example, let's look at the original, whole cell pertussis vaccine. During the 1970s, widespread concerns about the safety of the whole cell pertussis vaccine led to a rapid fall in immunization levels in the United Kingdom. More than 100,000 cases and 36 deaths due to pertussis were reported during an epidemic in the mid 1970s. Although the side effects of the original pertussis vaccine could be relatively severe, no child has died from the vaccine, though many died from pertussis.

Vaccines and the Infant Immune System

Do children receive too many vaccines? A recently published review by Offit et al.[2] found that, while babies are receiving more vaccines than in the past, they are in fact receiving fewer antigens (125 today compared to 3,000 in 1980) due to the "purified" content of modern vaccines. In addition, Offit et al. report that infant's immune systems are capable of responding to as many as 1 billion to 100 billion different antigens.

Vaccines, Autism and Other Diseases

But what about the reports that vaccines cause autism, diabetes, sudden infant death syndrome (SIDS), or multiple sclerosis? Reports have suggested a link between vaccination and disease because of the timing involved with receipt of vaccine and disease onset. If one event precedes another, it does not

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Listeriosis

Listeriosis is a potentially serious infection caused by eating food contaminated with bacteria called *Listeria monocytogenes*. The extent of food contamination with *L. monocytogenes* has been increasingly recognized in the United States. The disease is most dangerous to pregnant women, newborns, the elderly, and persons with weakened immune systems. According to the Centers for Disease Control and Prevention (CDC), there are an estimated 2,500 cases of listeriosis each year in the U.S. Of these, 500 die. Pregnant women are about 20 times more likely than other healthy adults to get listeriosis. About one-third of listeriosis cases occur during pregnancy. In pregnant women, spontaneous abortion, stillbirth, or birth of a severely ill baby can occur as a result of infection of the fetus. Healthy adults and children occasionally become infected with *L. monocytogenes*, but they rarely become seriously ill.

L. monocytogenes can be found in soil and water. In addition, wild and domestic animals can harbor these bacteria. *L. monocytogenes* has been found in a variety of raw foods, such as uncooked meats and vegetables, as well as in processed foods that become contaminated during or after processing, such as soft cheeses and cold cuts. Unpasteurized (raw) milk or foods made from unpasteurized milk may contain *L. monocytogenes*. These bacteria are killed by pasteurization, and heating procedures used to prepare ready-to-eat processed meats should kill the bacteria. However, sometimes contamination can occur after processing.

In recent years there have been a number of food product recalls due to contamination by *L. monocytogenes.* These recalls have involved specific dairy and prepared meat products, including many different varieties of hot dogs and cold cuts. Currently under investigation is a large, multi-state outbreak with cases dating back to July 2002. There are 53 culture-confirmed cases in this outbreak, including 8 deaths and 3 stillbirths or miscarriages. The cases are from New York, Pennsylvania, New Jersey, Delaware, Maryland, Connecticut, Michigan, and Massachusetts. These cases were linked through pulsed-field gel electrophoresis (PFGE), a DNA-fingerprinting technique performed at state laboratories in the U.S (for more information on PFGE, see

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Epidemiology

Invasive Meningococcal Disease—When to Administer Post-Exposure Prophylaxis (PEP)

Each year, 50-100 cases of invasive meningococcal disease are reported to the Massachusetts Department of Public Health (MDPH). Cases of invasive meningococcal disease are seasonal, with the majority of cases occurring in the winter and early spring.

A confirmed case of invasive meningococcal disease is defined as isolation of *Neisseria meningitidis* from a sterile site. It is important to remember that a sputum specimen positive for *N. meningitidis* does not indicate invasive disease and should not result in the administration of PEP to close contacts. Also, contacts of cases with viral meningitis or meningitis from causes other than *N. meningitidis* do not need to receive PEP.

When a case is identified, close contacts should be identified as soon as possible and receive appropriate antibiotic therapy. Close contacts include all household members and those individuals who have had intimate contact with the case's oral secretions (especially saliva). Close contact with these secretions can occur through kissing or through sharing food or eating and drinking utensils. Other types of activities to be considered include sharing lip gloss and cigarettes, water bottles, toys among infants and toddlers and shared office space, car pools, or other shared, enclosed spaces. When evaluating potential non-household contacts of a case, it is important to remember to ask about attendance at school, daycare, after-school programs and parties. Other potential contacts include baby sitters, close friends, relatives, visitors and work contacts.

All confirmed and suspect cases of invasive meningococcal disease should be reported immediately to the MDPH epidemiologist on-call at (617) 983-6800 during normal business hours or (617) 983-6200 during nights and weekends. The epidemiologist on-call will assist in evaluating potential exposures.

BT Workgroup InformationAvailable On The Web!

The Bureau of Communicable Disease Control shares responsibility for coordinating the workgroups of the statewide Emergency Preparedness and Response Program Advisory Committee. For a full listing of the workgroups, information about how you can get involved, a calendar of upcoming meetings, and minutes from past meetings, please go to the web site at: http://www.state.ma.us/dph/bioterrorism/advisorygrps/.

The *Guide to Surveillance and Reporting* is available online at www.state.ma.us/dph/cdc/gsrman/gsr.htm

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www.cdc.gov/pulsenet). In addition, one intact food product and 25 environmental specimens from a poultry processing plant yielded *L. monocytogenes*. The isolate from the food product had a different PFGE pattern; however, two environmental samples from floor drains shared an indistinguishable PFGE pattern with that of organisms isolated from the outbreak cases, suggesting that the plant may be the source of the outbreak. In response, the manufacturer has recalled 27.4 million pounds of fresh and frozen ready-to-eat turkey and chicken products (for more information on this recall, see http://www.fsis.usda.gov/oa/recalls/prelease/pr090-2002products.htm).

The following steps can be taken to prevent listeriosis and other foodborne illnesses:

- Thoroughly cook all raw meats.
- Wash raw vegetables thoroughly before eating.
- Keep uncooked meats separate from vegetables and from cooked foods and ready-to-eat foods.
- Wash hands, knives, and cutting boards after handling uncooked meats and dairy products.
- Avoid raw (unpasteurized) milk or foods made from raw milk.
- Always thaw ready-to-eat frozen food in the refrigerator or microwave, not on a counter.
- Thoroughly reheat food until steaming hot.

Additional recommendations for persons at high risk, such as pregnant women and persons with weakened immune systems, include:

- Avoid soft cheeses, such as feta, Brie, Camembert, blue-veined, and Mexican-style cheeses. Hard cheeses, processed cheeses, cream cheese, cottage cheese, and yogurt need not be avoided.
- Cook hot dogs until steaming hot before eating.

Although the risk of getting listeriosis from cold cuts and other foods from deli counters is relatively low, pregnant women and immunosuppressed persons may choose to avoid these foods or thoroughly heat them before eating. For further information regarding listeriosis, visit the CDC website at www.cdc.gov.

Medicare Reimbursement for State-Supplied Vaccine

The budget crisis and the increasing cost of influenza vaccine have resulted in the Massachusetts Department of Public Health (MDPH) decreasing the amount of flu vaccine it distributed for the 2002-03 flu season. In order to ensure the continuation and expansion of the adult vaccine program in Massachusetts, MDPH is working with the UMass Medical School Center for Health Care Financing to explore options for improving reimbursement for influenza vaccine. An important potential source of revenue is Medicare. Medicare reimburses for the cost of administering influenza and pneumococcal vaccine to Medicare beneficiaries, as well as for the cost of the vaccine itself.

Many local health departments and VNAs already participate in Medicare roster billing for the cost of administering state-supplied influenza and pneumococcal vaccine to Medicare beneficiaries in their clinics. This can be an important source of revenue for these agencies. For example, Joanne Martel, RN, Assistant Health Director/Public Health Nurse for the Andover Department of Community Development and Planning, estimates that 60% of the approximately 1,500 people she sees in her clinics are Medicare beneficiaries. Joanne reports that last year Andover received approximately $4,500 in reimbursement for the administration of state-supplied flu and pneumococcal vaccine to Medicare beneficiaries in her town.

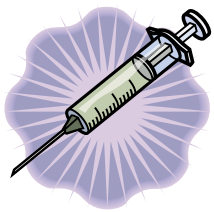
The Commonwealth proposes submitting copies of the same rosters to Medicare for reimbursement for the cost of the vaccine. Instructions on submitting copies of billing documents to MDPH will be forthcoming. MDPH encourages all facilities and institutions that receive state-supplied vaccine to enroll in the Medicare roster-billing program. For information on Medicare reimbursement, visit their website at http://www.cms.hhs.gov/preventiveservices/2.asp#1, or contact Roberta Tulley, Medicare Customer Service, at 207-294-6013.

Current Medicare Reimbursement Rates:

For Influenza Vaccine: $8.02 per dose

For administration of influenza and pneumococcal vaccine:

Middlesex, Suffolk and Norfolk counties: $4.77/dose
Remaining Massachusetts counties: $4.37/dose



MIIS Immunization Registry Update

The Division of Epidemiology and Immunization staff members Marcia Izzi, Steven Levy and Dennis Michaud attended the Centers for Disease Control and Prevention 3rd annual Immunization Registry Conference in Philadelphia during October. The conference brought together over 400 local, state, federal and private sector immunization registry partners, to promote knowledge and information about the development and use of immunization registries.

The theme of the conference was "Grow/Connect/Protect". The goal was to provide a forum to share and exchange programmatic, technical and scientific information and to build support for registries. Presentation topics included provider recruitment strategies, registry marketing techniques, operating registry systems and the use of registries for smallpox administration, adverse event tracking, and vaccine distribution.

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necessarily mean that the first event caused the second. To determine if there is a link between vaccine and disease, you must compare incidence of disease in vaccinated versus unvaccinated populations.

Federal government agencies have taken the lead with many vaccine safety research initiatives. One example is that the Institute of Medicine's Immunization Safety Review Committee has published a number of reports on different vaccine safety issues (www.iom.edu). These reports have shown that the currently available data do not support a link between vaccines and the variety of diseases for which they are believed to cause weakening of the immune system.

Currently there is a wealth of information confirming the fact that the benefit of vaccines outweighs the risk of the vaccine side effects and that we should continue in our goal of keeping immunization rates high in Massachusetts. For more information concerning vaccine safety, visit these websites (www.cdc.gov/nip and www.chop.edu).

[1]Gellin, B.G., et al. Pediatrics. 2000;106: 1097-1102
[2]Offit, P.A., et al. Pediatrics. 2002;109: 124-129

HIV/AIDS Surveillance

Update On Mortality Among AIDS Cases In Massachusetts

Since the mid 1990s, there has been a dramatic decline in deaths among people reported with AIDS. The introduction of highly active antiretroviral therapy (HAART) in 1996 had a substantial impact on the survival time of persons with HIV infection and AIDS. Decreases in deaths among persons with HIV infection and AIDS are evident in all demographic groups in Massachusetts. However, differences in the natural historyof HIV disease in various populations and the evidence of comorbidity, such as hepatitis C, play a role in differential mortality trends among subgroups.

Declines in deaths also reflect declines in AIDS incidence in different populations. The number of deaths in persons with AIDS increased each year from the beginning of the epidemic until 1995, reflecting the increase in the incidence of AIDS through the 1980s and early 1990s. However, declines in the number of deaths in 1996 and 1997 were considerably greater than expected based on incidence trends. As of November 2002, 17,626 persons with AIDS were reported among residents of Massachusetts, and 9,932 have died.

There has been a proported decrease in deaths among whites diagnosed with AIDS and increases among blacks and Hispanics. There has been a sustained increase in the proportion of deaths occuring among those with injection drug use (IDU) as a reported risk for HIV infection and a decrease among men who have sex with men (MSM). These trends in mortality mirror AIDS incidence.

Deaths among people with AIDS in Massachusetts peaked at 1,206 in 1994, dropping to 332 in 2001, a decrease of 73%. From 1995 (the peak year for deaths among females at 232) to 1998, deaths among females with AIDS decreased by 70% (232 to 69, annually). However, deaths among females increased to 76 in 1999, 79 in 2000 and 94 in 2001. Deaths among males with AIDS peaked at 975 in 1994 and decreased by 76% to 238 in 2001.

Over time, people of color have accounted for an increasing proportion of deaths among people with AIDS. In 1991, whites accounted for 69% of deaths among people with AIDS and 31% for people of color account for 31% (18% blacks and 13% Hispanics). In 2001, whites accounted for 54% of deaths compared to 46% for people of color (28% black and 18% Hispanic).

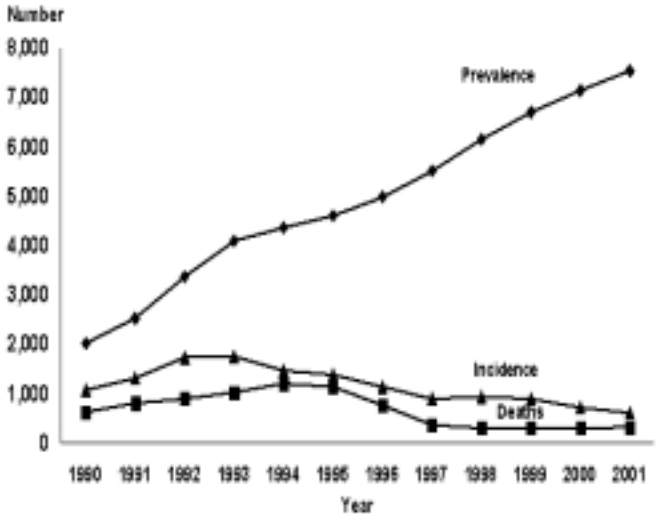
Through 1993, the MSM exposure category accounted for the largest number of deaths among people reported with AIDS. In 1994, the number of deaths among persons with AIDS where IDU was the mode of exposure (464 or 39%) surpassed the number of deaths where MSM was the mode of exposure (454).

From 1993 (the peak year of deaths for MSM, 457) to 1999 and 2000 (the years with the lowest MSM deaths, 57 each year) the number of deaths decreased by 88%. In 2001, the number of MSM deaths increased to 72. From 1994 (the peak year of deaths for IDU, 464) to 2001, the number of deaths among people with AIDS with IDU mode of exposure decreased by 65%. In 1995, deaths among people with AIDS with heterosexual risk peaked at 130 deaths.

Despite overall declines in mortality among persons with HIV/AIDS, mortality has been experienced differentially among various subpopulations. Even in this era of highly effective treatment, addressing disparities in care, preventing secondary transmission, and meeting the social and medical needs of persons living with HIV or AIDS remain significant public health challenges.

The death data presented in this analysis include all deaths among people reported with AIDS in Massachusetts including deaths that were due to causes not related to the person's HIV infection, such as liver disease, heart disease, non-HIV related cancers, drug overdoses, accidents, homicide and suicide where HIV infection may not be indicated on the death certificate. This explains differences between data on deaths among AIDS cases in Massachusetts as reported to the HIV/AIDS Surveillance Program compared to the data reported as due to HIV/AIDS in "Massachusetts Deaths."

AIDS Incidence, Prevalence, and Deaths by Year:
Reported AIDS Cases, Massachusetts, 1990-2001



Data Source: MDPH HIV/AIDS Surveillance Program, Data as of 1/1/2003

You Be The Epi

Who's the Source Case?

You received a telephone call the middle of October from the infection control practitioner (ICP) nurse at the local community hospital, reporting a number of tuberculin skin test (TST) conversions among staff on all shifts of one patient unit. Nineteen staff who worked on or frequented the unit, including nurses, respiratory therapists (RT), miscellaneous staff, and one physician, had converted their TSTs in the last several months.

What additional information would be helpful in the investigation?

- *Information regarding the hospital's testing procedures.* Who administered the TSTs and were they experienced in administering and reading the tests? Which PPD solution was used in the TST? Was there a recent change in PPD product? What size were the reactions to the TSTs? Did anyone exhibit symptoms of TB? What was the staff-testing schedule and when did the exposed staff receive their last TSTs?

- *The physical layout of the unit and its relationship to other units, ventilation patterns, and the operation of any isolation rooms*. What is the physical layout of the unit and it's physical proximity to other units? How is the air circulated and ventilated on the unit? Are there negative pressure isolation rooms on the unit and have they been checked to ensure the ventilation system is running properly? Does the hospital have a TB Exposure Plan? Were the TB isolation precautions followed?

- *Clinical profile of patients on the unit*. What has been the clinical profile of the patients on the unit? Did any of the patients have respiratory symptoms? Have any of the patients had a history of exposure to someone with infectious TB? Did any of the patients have symptoms consistent with active TB disease? Did any of the patients have conditions that put them at increased risk of developing TB after becoming infected, such as HIV, or diabetes? Were respiratory procedures conducted that might have caused coughing or some other aerosolization of secretions on the unit?

What investigation activities would you recommend?

- Consider inviting the state TB Division to assist with the investigation.

- Expand the testing of other hospital staff systematically. Try to narrow down the potential exposure period, by examining employment histories, work assignments, and TST results. Several employees had started or left employment in the last several months, establishing a three-month exposure period.

- Conduct an investigation to identify potential infectious patients and review their clinical records. Prioritize patients with respiratory disease. Ask the Medical Records Department to generate lists of patients who had diagnoses of respiratory disease.

- Conduct an epidemiological investigation to identify and track patient/staff interactions to analyze potential exposure patterns. Look at staffing patterns and work assignments to see if there were any relationships. Include staff that worked part-time or were not on the unit often.

- Send a letter to notify physicians whose patients were identified as being on the unit during the exposure period. Request that they and their patients have a TST and send the results to the hospital.

- Follow-up on any source case or secondary cases that are identified

- Document the results of the investigation.

Save The Date

Regional TB Update: *The next regional TB Update conference will be held at the Lahey Clinic in Bulington on Thursday, January 30, 2003. For more information call Debra Thimas at the Metrowest TB regional office at 781-828-7041.*

The Eighth Annual Massachusetts Immunization Skills Building Conference: *8:30 AM to 4:30 PM on May 22, 2003 at the Best Western Royal Plaza Hotel in Marlborough, MA. For more information, contact the Massachusetts Immunization Program at (617) 983-6800.*

Refugee and Immigrant Health

Victims of a Severe Form of Trafficking

There is increasing recognition that slavery still exists; that men, women and children are trafficked; and that the toll on societies, families and individuals is tremendous. Worldwide, trafficking in persons is estimated to victimize some 700,000 individuals annually, most of them women and children. The number of women and children trafficked into the U.S. each year is thought to be 50,000; the number of men is not known. In response, the U.S. Congress passed, and President Clinton signed into law, the Trafficking Victims Protection Act of 2000 [Public Law 106-386].

The Trafficking Victims Protection Act aims to reduce trafficking of persons into the United States through increased law enforcement to ensure effective punishment of traffickers, to protect victims and to provide federal and state assistance to victims. Provisions in the law make adult victims of severe forms of trafficking who have been certified by the Department of Health and Human Services, eligible for refugee benefits and services. Minors are also eligible for benefits and services but do not need to be certified.

Severe forms of trafficking in persons are defined in the law and include sex trafficking and involuntary servitude, peonage, debt bondage, or slavery. The certification process for adults involves the determination that an individual is willing to assist in the investigation and prosecution of traffickers and that their continual presence in the U.S. is essential to those actions.

Refugee benefits and services are time-limited and include medical benefits, employment services, English language training, and cash assistance, with the goal of self-sufficiency. Refugee health assessment providers will be responsible for the initial medical evaluation of victims of trafficking. Like asylees, victims of trafficking do not have overseas medical screening. Many may have been victims of sexual abuse and violence. Consequently, medical clinicians should be particularly sensitive to these issues when evaluating victims of trafficking. Testing for sexually transmitted diseases, HIV, and other diseases spread by contact with bodily fluids should be considered. In regards to exposure to violence, clinicians should consider mental health screening for depression, anxiety, and posttraumatic stress disorder and refer patients to experienced mental health clinicians, if deemed appropriate.

During fiscal year 2001 (October 1, 2000 through September 30, 2001), the Office of Refugee Resettlement, Department of Health and Human Services, issued 196 certification letters to adults. In addition, four minors were issued eligibility letters. Most were females (177/200). Although victims of trafficking were in 19 states plus the District of Columbia, nearly 75% were in California, Hawaii, Texas, and Pennsylvania. Staff from the Office of Refugee Resettlement also conducted outreach and education sessions throughout the U.S. to increase awareness about trafficking in persons.

Sources:
Department of Health and Human Services, Office of Refugee Resettlement State Letter #01-13; on the web at www.acf.dhhs.gov/programs/orr
Department of Health and Human Services, Office of Refugee Resettlement: Trafficking Victims Protection Act of 2000 - FY2001 Annual Report

Refugee Admissions Update

Refugee admissions during the federal fiscal year 2002 that ended on September 30, 2002 were profoundly affected by the September 11, 2001 terrorist attacks. Enhanced security measures slowed both overseas processing and entry into the United States. As a result, just over 27,000 refugees arrived in the U.S. during the year – far short of the 70,000 admissions that had been authorized. In Massachusetts, 997 refugees were resettled, compared with 2,061 in the previous year.

President George W. Bush signed the Presidential Determination on FY 2003 Refugee Admissions to the United States on October 16, 2002. Although a total of 70,000 admissions were authorized, 20,000 were in the "unallocated reserve" category. These reserve admissions have not been used in recent years, leaving the projected ceiling for admissions at 50,000. The admission numbers are allocated by region as follows:

Region	*Ceiling*
Africa	20,000
East Asia	4,000
Eastern Europe	2,500
Former Soviet Union	14,000
Latin America/Caribbean	2,500
Near East/South Asia	7,000

Refugee advocates and many members of Congress had called for an increase in FY2003 admission ceilings to at least 100,000 in order to accommodate those refugees who would have been admitted in FY2002 as well as those currently in need of resettlement.

Community-Based TB Prevention

The most significant challenge to the elimination of tuberculosis (TB) in Massachusetts is growing populations of people with latent TB infection who are at highest risk of progressing to TB disease. During the six year period from 1993 to 2001, tuberculosis was diagnosed among 2663 Massachusetts residents, 63% (1691) of whom were foreign-born. Over time, the percentage of TB cases in non-US born individuals has continued to rise. In 2001, 77% of TB cases were among persons born outside the United States; in 1986, the proportion was only 31%. The epidemiology of TB among the foreign-born in Massachusetts reflects the heterogeneity of the resident foreign-born population as well as the differential risk for disease due to factors such as exposure to TB prior to emigration, age, and length of time in the US.

In 1997, with the help of The Medical Foundation, the Division took its first ambitious steps toward community–based prevention. While maintaining its core functions for TB control, the Division carried out team building exercises in order to focus on communities at highest-risk for developing TB disease. Under the guidance of a CDC Prevention Specialist, the Division partnered with nontraditional agencies/organizations to increase awareness of TB in three selected communities. The main purpose of these projects has been to build partnerships with key individuals and community groups at the local level in order to share ownership of TB control within these selected communities. Our initiative in Cambridge, which focuses on the Haitian Community, is one of the original projects.

Cambridge Project

In early 1999, the Division approached various Haitian community agencies to solicit input in developing a community approach to TB prevention. These initial meetings led to a local Haitian task force on TB. This task force was comprised of many individuals and representatives from various agencies and local community groups in Cambridge. The initial purpose of this task force was to raise awareness of latent TB infection (LTBI) in the community as well as among local Haitian service providers.

In order to identify and develop a unified intervention, the task force decided on a two-step approach to informing the local community about TB. First, the taskforce worked with local Haitian radio stations to invite speakers to talk about TB on the radio. The goal was to educate radio listeners about the risks of TB. Secondly, the task force decided to hold two community focus groups to help identify and develop specific strategies that would be effective in presenting TB prevention and screening in a culturally appropriate manner. As a result of these focus groups, the taskforce recommended that the TB Division fund a TB video that would be shown in beauty salons and barbershops. The barbershops and beauty salons identified by our community partners were gathering places for the local Haitian community and locations considered appropriate to share health-related information.

With the assistance of CDC funding, the Division was able to partner with the Community Affairs Program of the Cambridge Health Alliance. The Alliance began developing a script and producing a Haitian TB Prevention video in late 2000. With the completion of the Haitian-Creole video in May of 2001, regular outreach sessions began in June 2001 at five local barbershops and beauty salons. The showing of the video at local beauty salons and barbershops was tied to a raffle. After watching the video, those completing the raffle ticket information were asked questions about latent TB infection. Raffle winners received free hair care products and services at that salon.

As a result of initial efforts, the community requested additional health information from the local and state health departments. On several occasions, physicians have gone out to the barbershops and beauty salons and provided health education on TB, STDs, prostate cancer, high-blood pressure, and diabetes. In May 2002, our prevention partners broadened the potential viewing audience by showing the video on local cable access TV.

The Cambridge Community Affairs Program has built upon initial efforts by incorporating TB education into their recently created Volunteer Health Advisor program. The Volunteer Health Advisor program was developed as part of the department of Community Affairs "100% Access, 0 Disparities Campaign". The purpose of the program is to increase access to preventive health care services and reduce health disparities among the uninsured. The Volunteer Advisors act as extensions of the Community Health Workers and, as leaders within their communities, can reach the most 'hard to reach' segments of the community. Currently there are over ten Community Health Advisors in the program and each is a resource for health care access as well as education on HIV & AIDS, chronic disease, cancer and TB.

Public Health Nurse Spotlight

In this Update issue and in upcoming issues, the TB Division would like to recognize an individual whose hard work and dedication has made a difference in TB control. For this issue we are highlighting Public Health Nurse Anne Donovan of the Lawrence Health Department. Anne has worked at the Health Department for more than 20 years; in addition to overseeing blood pressure and flu clinics, and administering immunizations, Anne is clinic nurse for the TB clinic, held twice monthly at Lawrence General Hospital. She has two nursing coworkers and a clerk now, but that wasn't always the case – for several years Anne worked alone, covering all of the health department's communicable disease issues.

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CD UPDATE
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Public Health Nurse continued from page seven

Anne is not one to talk about her good deeds and accomplishments, but her colleagues will say that her dedication to her patients and to the Lawrence community is unsurpassed. As case manager for TB patients and their contacts, Anne has given countless hours of her own time in conducting home visits, doing DOT, and monitoring patients for treatment adherence. When the health department was understaffed, she worked through her lunch break. When no car was available for her use, she walked to see her patients. Anne has invited patients into her home for DOT because it was convenient for them. ("You have to bend a little," she says.) She has given homeless patients her own money to buy food. And because Lawrence has a large Spanish-speaking population, Anne taught herself to speak Spanish to facilitate communication and trust with her patients.

In answer to the question, what is the best part of her job, Anne replied, "Contact with the people and the community – and my coworkers are great." When asked about challenges in her job as a TB nurse, Anne noted the difficulties in finding contacts to TB cases. ("No one ever has any friends or relatives!") She counters this problem by looking for signs of other people in the house, being very specific with her questions, and explaining what a contact is.

Anne credits her work ethic to her role models, retired Lawrence Health Department nurses Yvonne Dube and Lucy Cameron, saying they taught her not to judge people by external standards – everyone is different. Of her coworkers, Brian Zahn, RN, Catherine Ouellette, RN, and Ellie Guerrero, Anne says, "When you work with good people, the job is easy."

The TB Division is pleased to recognize Anne Donovan for her outstanding achievements in TB control and for her dedication to the community and the people of Lawrence.

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